WISCONSIN MEDICAID
RESPIRATORY CARE SERVICES / PLAN OF CARE (RCS/POC) COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form and is formatted exactly like this form. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgment about the case.

Submitting Prior Authorization Requests
These instructions are for the plan of care that providers are to attach to PA requests for respiratory care services (RCS). Attach the completed Respiratory Care Services/Plan of Care (RCS/POC) to the Prior Authorization Request Form (PA/RF) when submitting a PA request for RCS.

Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Providers who wish to continue submitting PA requests by mail may do so by submitting them to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

Comments Sections on RCS / POC
The comments sections throughout this document should be used to provide additional information if necessary.

SECTION I RECIPIENT / PROVIDER INFORMATION

Include all of the following information on the areas marked on the top of each page of the RCS/POC.

Name — Recipient
Enter the recipient's last name, followed by his or her first name and middle initial.

Recipient Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the recipient's Medicaid identification card or the Eligibility Verification System to obtain the correct identification number.

Name — Provider
Enter the provider's name.

Wisconsin Medicaid Provider Number
Enter the provider's Medicaid number. Use the billing number the provider will use on Medicaid claims.

SECTION II RESPIRATORY CARE SERVICES REQUESTED

Service (Airway Management)
Answer all questions in this subsection. Where requested, indicate the frequency of the care in the units indicated. If airway humidification is required, indicate at least one type of humidification used.

List Scope of at Least Three Parameters
Indicate at least three parameters to be monitored (e.g., vital signs, breath sounds, and secretions). For each parameter, indicate the number of times that parameter is monitored in a 24-hour period.

Service (Ventilatory Support)
Answer all questions in this subsection. Where requested, indicate the number of hours that mode of ventilation is used in a 24-hour period. In addition, if the mode of ventilation is "Other," specify the type of ventilation used and frequency.

List at least two parameters used for monitoring the ventilator (e.g., ventilator and alarm settings), and indicate the frequency for each parameter (the number of hours in a 24-hour period).

Identify at least one step in the provider's plan for ventilator maintenance, and indicate the number of times per week that step is performed.

SECTION III EMERGENCY PLAN

Answer all questions in this section. If there are no events to which this recipient is susceptible, record "NONE."

List at least two resources (e.g., emergency equipment, an emergency power source) used for back-up equipment.

Identify at least one monitoring device or adjunctive technique used by the recipient, and indicate the frequency for each (the number of times in a 24-hour period).

SECTION IV FUTURE AND OTHER CARES

If recipient is to be weaned from the ventilator, complete the appropriate questions.

Indicate whether the recipient is receiving other services by checking the appropriate box(es).

SECTION V CASE COORDINATION

Complete all applicable information about case coordination and the case coordinator for this recipient.

SIGNATURE

Sign and date the RCS/POC. If the form is not signed by the applicable individuals, the entire PA request will be returned to the provider.